MANUAL 2012

# EXPENDITURE ANALYSIS OF PEPFAR PROGRAMS IN COUNTRYNAME

*V 0713*

This manual is designed to assist PEPFAR-implementing partner organizations in COUNTRYNAME collect and submit relevant program information and financial data for the PEPFAR Expenditure Analysis Initiative. The subsequent instructions and operational definitions refer to the data collection instruments provided by the PEPFAR Coordinator/Secretariat

PEPFAR FINANCE AND ECONOMICS WORK GROUP (FEWG)

## ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| AM | Activity manager |
| AOTR | Agreement officer's technical representative |
| APR | Annual progress report |
| ARVs | Antiretroviral drugs |
| ART | Antiretroviral therapy |
| BS | Blood safety |
| CBCTS | Community-based care, treatment, and support |
| CBTC | Community-based testing and counseling |
| COTR | Contracting officer's technical representative |
| CSW | Commercial sex worker |
| EA | Expenditure analysis |
| FBCTS | Facility-based care, treatment, and support |
| FY | Fiscal year |
| GP | General population |
| HSS | Health system strengthening |
| HTC | HIV testing and counseling |
| IDU | Injection drug user |
| IC | Infection control |
| IP | Implementing partner |
| MARP | Most at-risk population |
| M&E | Monitoring and evaluation |
| MSM | Men who have sex with men |
| NGI | Next generation indicator |
| OVC | Orphans and vulnerable children |
| PC/S | PEPFAR Coordinator/Secretariat |
| PEP | Post-exposure prophylaxis |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PITC | Provider initiated testing and counseling |
| PROMIS | PEPFAR Records and Organization Management Information System |
| PMTCT | Preventing mother-to-child transmission |
| SAPR | Semi-annual progress report |
| SI | Strategic information |
| SORP | Sexual and other risk prevention |
| TA | Technical assistance |
| USG | United States Government |
| VCT | Voluntary counseling and testing |
| VMMC | Medical male circumcision |

# 1.0 SUMMARY

The United States Government (USG) is conducting an Expenditure Analysis (EA) of PEPFAR programs in COUNTRYNAME for fiscal year (FY) 2012, 01 October 2011–30 September 2012. The goal of this interagency exercise is to better understand the costs USG incurs to provide a broad range of HIV services and support and subsequently use this information to estimate the resources needed to support programs in the future. Your organization is being asked to report program information and total expenditures for FY 2012 by program area (as defined by PEPFAR) and sub-national level. Data should be collected and submitted using the PEPFAR Records and Organization Management Information System (PROMIS). This manual provides instructions for accessing the PROMIS website; downloading, completing and submitting the data collection workbook; and requesting technical assistance. Further, this manual provides operational definitions for PEPFAR program areas and financial accounting (cost) categories, and recommended methods for categorizing and allocating expenditures.

## 1.1 TIMELINE

An informational session for PEPFAR implementing partners (IPs) will be held **XX.** Information on this session will be provided by the PEPFAR Coordinator/Secretariat (PC/S). Your organization is requested to complete and submit the data collection workbook via PROMIS no later than 16 November 2012. Data will not be accepted beyond this date. Your organization will receive a summary report of cleaned and analyzed data no later than **1 February 2012**.

The EA Initiative is an ongoing PEPFAR activity. Your organization will be asked to report on PEPFAR expenditures in a similar format in future fiscal years.

## 1.2 CONFIDENTIALITY

The program and expenditure information you submit via PROMIS will not be shared outside of USG country team in COUNTRYNAME. Summary data (not partner-specific), such as averages and ranges, may be shared with USG agency headquarters and other stakeholders. A complete description of privacy practices are posted and may be viewed on the PROMIS website and in Appendix I to this document.

## 1.3 NOT AN AUDIT

The goal of this exercise is to better understand the actual USG costs of providing HIV services to beneficiaries in order to improve program planning. Understanding that PEPFAR budget codes do not align directly to EA program area categories and disbursements are often delayed from the fiscal year in which funds are obligated, there will be no effort to link proposed FY 2012 budgets to the data your organization provides on actual expenditures.

## 1.4 FEEDBACK

Your feedback on the data collection workbook and process is highly valued. You will have several opportunities to share your experience and provide feedback so that institutionalization of this process in the future minimizes burden and maximizes the usefulness of results, both for your organization and USG agencies.

## 1.5 REQUESTED DATA

You are requested to provide program information and comprehensive expenditure data on your PEPFAR-supported programs for FY 2012. Some standard categories and definitions for program outputs and expenditures are listed below; however, some data may be requested that is unique to each program area.

## PROGRAM INFORMATION

Program information requested for EA is primarily aligned with the indicator data routinely supplied to PEPFAR through the Semi-annual and Annual Progress Reports (S/APR). If your organization reported indicators to PEPFAR in FY 2012, these data should also be included in the EA submission. Not all required PEPFAR indicators are needed for this activity and specific indicators and additional information will vary by program area. Some program information that has not already been supplied to PEPFAR COUNTRYNAME through the S/APR process may be requested but will not be required. A complete list of program information categories and descriptions can be found in section 2.2.

## EXPENDITURES

Your organization is requested to report total PEPFAR expenditures for FY 2012 by mechanism, program area, and region. Expenditures are first classified as those that occur at the facility/site/implementation-level, and those that support the broader program or health system. Within each program area, expenditures at the site-level are categorized by major cost category—*investment* or *recurrent*—and are further disaggregated by common expenditure categories associated with each. PEPFAR expenditures incurred above the site-level for *program management (PM)*, *strategic information (SI)* and *health system strengthening (HSS)* are categorized first by location (provincial, national, or above-national), and second by cost category.

The goal in reporting expenditure information is to account for every PEPFAR dollar spent over the fiscal year. Expenditures should not be reported by PEPFAR budget code, but according to how PEPFAR dollars were actually spent to deliver service and/or support. Any site-level expenditures should be classified by PEPFAR program area, by major cost category (investment or recurrent expenditure) and reported according to the appropriate sub-category (e.g. vehicles, personnel, office equipment, etc.). For programs that are not facility-based (e.g., community-based care, treatment, and support), additional disaggregation of expenditures by intervention type may be asked as appropriate to enhance interpretation and usability of results. Any expenditure that did not originate at the site/point-of-service should be recorded as program management, strategic information, or health system strengthening expenditure. Full descriptions of each expenditure category can be found in sections 2.3-2.6.

## CURRENCY CONVERSION

Please report all expenditures in United States Dollars (USD). Please apply the exchange rate of **XX $$$$** per 1 USD for all converted expenditures.

## SHARED EXPENDITURES

Some common types of expenditures may be shared by program area-specific activities, such as personnel and vehicle fuel and maintenance[1]. Shared expenditures must be allocated to the appropriate category in order to accurately estimate expenditures for specific HIV services and target populations. This manual provides some general guidance and examples of methods for allocating shared expenditures in section 3.0. Each organization is different and there is no single method for allocation that will accurately define the program for all organizations supplying data. Technical assistance (TA) can be provided in-person and remotely to help your organization work through specific challenges pertaining to allocation. Information on requesting TA can be found in section 4.0.

[1] Example: the fuel purchased for a vehicle that is used for both mobile HIV testing and counseling and services for orphans and vulnerable children

## 1.6 ACCOUNTING METHOD

For the purposes of this analysis we ask your organization to use the cash basis of accounting and recognize disbursements as expenditures. Hence, "financial expenditures" are cash disbursements from the perspective of the prime contractor or awardee.

Examples of transactions that would be considered a financial expenditure for this analysis:

- Cash paid for an asset, regardless of the asset's useful life
- Prepayment for rent, supplies or utilities

Transactions that would not be considered a financial expenditure for this analysis:

- An asset purchased and received, for which payment has yet to be made
- Expenditures accrued but not yet paid
- Issuance of a note or other promise to pay cash at a time in the future

### FUNDS DISPERSED TO SUB-GRANTEES

Some organizations may have funds they dispersed to sub-grantee partners over FY 2012. The prime implementing partner is responsible for capturing expenditure data attributable to each sub-grantee organization and including those data in the prime partner submission.

# 2.0 DATA COLLECTION WORKBOOK

The data collection workbook for this activity should be downloaded from the following website:

*https://pepfarpromis.net/Vietnam.PROMIS.web/*

The data collection workbook is in Excel 2007 format. Information on each worksheet is provided below. Please complete each worksheet and data field that pertains to your organization. If data entry cells are left blank, the default value will be zero (0). Please do not adjust the structure of the workbook/worksheets or adjust the formulae in any cell.

Each worksheet will provide hyperlinks to fields for entering text or notes that may help explain your submission. We encourage your organization to utilize these text fields to further explain the data provided, especially if an equation was used to allocate shared expenditures that differs from the recommended method. Please indicate the worksheet and cells referenced for each notation.

Sections 2.1-2.6 below provide detailed descriptions of the requested data for each worksheet in the data collection workbook. Should your organization have specific questions, please request TA (section 4.0).

*TIP: Enter expenditure data on the site-level worksheet first. This will help provide the information needed to accurately allocate expenditures on other worksheets.*

## 2.1 INSTRUCTIONS AND PARTNER INFO

The *Instructions* worksheet provides information on naming the Excel file prior to submission, as well as the submission process. Please refer to this manual for assistance with providing the requested data, including operational definitions and allocation methods. The *Partner Info* worksheet requests information on your organization's name, contact information, and mechanism. Please ensure each partner information field is complete. If you do not know your mechanism ID, please contact your AM/A/COTR to retrieve the number.

## 2.2 PROGRAM INFORMATION

The program information worksheet is designed to collect information on program achievements and other characteristics that enable the EA team to allocate expenditures between program areas, intervention types/models and/or target populations. Most categories are aligned with PEPFAR next generation indicators (NGIs). If your organization typically reports indicators to PEPFAR through the S/APR process, or is involved in direct service provision to beneficiaries, you will need to complete this worksheet. **Table 1** provides a list of required program information (both NGI and other) with descriptions and instructions for each entry category. Please only complete data entry fields that pertain to your organization's programs and operations. If you are unsure if a specific category pertains to your organization, please request TA (section 4.0).

**Table 1. EA Program Information Categories and Descriptions with NGI Reference**

| Indicators by Program Area | Description |
|---|---|
| **Facility-based Care, Treatment and Support (FBCTS)** | |
| Number of Current Clinical Patients at Start of Period, by Patient-type (Month 0) | For each indicator below, please report the number of current patients at the beginning of the period (1 October 2011). These will align with the numbers your organization reported to PEPFAR as part of the APR 2011. |
| Current Adult Pre-ART patient (15+ years) | Related to NGI C2.1.D, *Number of HIV-positive adults and children receiving a minimum of one clinical service*; however, there is one required adjustment. The goal of this indicator is to understand how many individuals are receiving PEPFAR-supported clinical care through health facilities. Please deduct the number of individuals supported with clinical care in community settings (outside of health facilities), including those receiving home-based care. Those receiving community- and home-based clinical care should be reported in CBCTS section. |
| Current Pediatric Pre-ART patients (< 15 years) | |
| T1.2.D: Current Adult ART patients (15+ years) | The same as indicator NGI T1.2.D, *Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]*. The goal of this indicator is to understand how many individuals are receiving PEPFAR-supported ART through health facilities. Please deduct any patients counted here that are receiving community- or home-based ART; these individuals should be counted in the CBCTS section. |
| T1.2.D: Current Pediatric ART patients (<15 years) | |
| Number of Current Clinical Patients at Mid-point of Period, by Patient-type (Month 6) | For each indicator below, please report the number of current patients at the mid-point of the period (1 April, 2012). These will align with the numbers your organization reported to PEPFAR as part of the SAPR 2012. |
| Current Adult Pre-ART patient (15+ years) | Related to NGI C2.1.D, *Number of HIV-positive adults and children receiving a minimum of one clinical service*; however, there is one required adjustment: please deduct the number of individuals supported with clinical care in community settings (outside of health facilities), including those receiving home-based care. |
| Current Pediatric Pre-ART patients (< 15 years) | |
| T1.2.D: Current Adult ART patients (15+ years) | The same as indicator NGI T1.2.D, *Number of adults and children with advanced HIV infection receiving antiretroviral therapy(ART) [CURRENT]*. The goal of this indicator is to understand how many individuals are receiving PEPFAR-supported ART through health facilities. Please deduct any patients counted here that are receiving community- or home-based ART; these individuals should be counted in the |
| T1.2.D: Current Pediatric ART patients (<15 years) | |

| | |
|---|---|
| | CBCTS section. |
| Number of Current Clinical Patients at End of Period, by Patient-type (Month 12) | For each indicator below, please report the number of current patients at the end of the period (30 September 2012). These will align with the numbers your organization reported to PEPFAR as part of the APR 2012. |
| Current Adult Pre-ART patient (15+ years) | Related to NGI C2.1.D, *Number of HIV-positive adults and children receiving a minimum of one clinical service*; however, there is one required adjustment. The goal of this indicator is to understand how many individuals are receiving PEPFAR-supported clinical care through health facilities. Please deduct the number of individuals supported with clinical care in community settings (outside of health facilities), including those receiving home-based care. Those receiving community- and home-based clinical care should be reported in CBCTS section. |
| Current Pediatric Pre-ART patients (< 15 years) | |
| T1.2.D: Current Adult ART patients (15+ years) | The same as indicator NGI T1.2.D, *Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]*. The goal of this indicator is to understand how many individuals are receiving PEPFAR-supported ART through health facilities. Please deduct any patients counted here that are receiving community- or home-based ART; these individuals should be counted in the CBCTS section. |
| T1.2.D: Current Pediatric ART patients (<15 years) | |
| Clinic Visit: Estimate the average number of times over the year each patient-type received a clinic visit | For each patient type supported with FBCTS, please indicate the average number of times each patient received a clinic visit over the course of the year. Fractions are acceptable. These should be your best estimates using clinical records or program staff input and reflect actual service delivery, not guidelines. The purpose of this information is to allocate resources between the patient types so that more accurate and specific unit expenditure estimates can be generated. If your organization reports indicators for FBCTS but does not actually provide support for clinic visits, you are not required to complete this section, but will need to provide an explanation in the comments section for *Indicators- FBCTS* in the tool. |
| Adult Pre-ART patient (15+ years) | |
| Pediatric Pre-ART patients (< 15 years) | |
| Current Adult ART patients (15+ years) | |
| Current Pediatric ART patients (<15 years) | |
| Lab Services: Estimate the average number of times over the year each patient-type received a lab service, including CD4 tests, biochemical panels, hematology tests, and viral load assessments. | For each patient type supported with FBCTS, please indicate the average number of times each patient received a lab service over the course of the year. Fractions are acceptable. These should be your best estimates using clinical records or program staff input and reflect actual service delivery, not guidelines. The purpose of this information is to allocate resources between the patient types so that more accurate and specific unit expenditure estimates can be generated. If your organization reports indicators for FBCTS but does not actually provide support for CD4s, you |
| Adult Pre-ART patient (15+ years) | |
| Pediatric Pre-ART patients (< 15 years) | |

| | |
|---|---|
| Current Adult ART patients (15+ years) | |
| Current Pediatric ART patients (<15 years) | are not required to complete this section. |
| **Community-based Care, Treatment and Support (CBCTS)** | |
| Number of beneficiaries reached with CBCTS | Related to NGI C1.1.D, *Number of eligible adults and children provided with a minimum of one care service*. This NGI is an umbrella care indicator and, by definition, includes those reached with clinical and other types of care, as well as, those provided care in health facilities or in community settings. For the purposes of EA, one adjustment is requested to determine the number reached through community-based care: please deduct all individuals reported in this indicator receiving care and support in health facilities. These individuals should be counted in the FBCTS section. |
| Number of beneficiaries receiving services in each of the following service categories: | Please indicate the number of beneficiaries that were reached with community-based services and support in each of four service categories. It is understood that some individuals are reached with more than one service, and conversely, not all individuals receive all types of services. Therefore, the sum of beneficiaries reached across all service categories may be higher than the total number reported reached through CBCTS (previous indicator). The sum across all service categories should not be lower than the total number reported in CBCTS. |
| Medical Care (not facility-based) | |
| Economic Strengthening | |
| Social, Psychological and Spiritual Care | |
| Nutrition and food security | |
| **Prevention of Mother-to-Child Transmission (PMTCT)** | |
| Number of Pregnant women tested for HIV and received results | Related to NGI P1.1.D, *Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)*. For the purposes of EA, please only report the number of women who were HIV tested by your organization and received their test results. Please do not include women who were not tested by your organization. Please report women tested through PMTCT in this section and not HTC. |
| P1.2.D: Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission | This indicator is the same as NGI P1.2.D, *Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission*. |
| Number of HIV-exposed infants tested for HIV | This is the same as the COUNTRYNAME revised NGI indicator C4.1.D, *Number of infants born to HIV-positive women (or exposed infants) who received an HIV test within 18 months of birth.* Please report infants tested through |

| | |
|---|---|
| | PMTCT in this section and not in HTC. |
| Number of HIV-exposed infants who received HIV care | This is related to NGI C4.2.D, *Percent of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth*; however, there are two major differences: (1) the reported number should be the numerator only (total number reached) and (2) the indicator should include infants supported with *any* type of care service through PMTCT, not just the provision of CTX. |
| Of the reported number of women and infants tested for HIV and received results, indicate the number identified positive for HIV through PMTCT: | The following indicators are a subset of the total number of pregnant mothers and infants tested (NGIs P1.1.D and C4.1.D, respectively). |
| Pregnant Women | A disaggregation requirement for NGI P1.1.D, *Number of new positives identified* |
| Infants | A disaggregation requirement for NGI C4.1.D, *Number of infants who were confirmed HIV positive during 18 months after birth* |
| **HIV Testing and Counseling (HTC)** | |
| Number of individuals who received HTC services for HIV and received their test results | Related to NGI P11.1.D, *Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results*; however, there is one required adjustment: please deduct testing and counseling for pregnant mothers and infants provided through a PMTCT site. These individuals should be counted in the PMTCT section. |
| Number of Individuals tested and identified as HIV positive | Subset of NGI P11.1.D. |
| PITC: Number of individuals tested through provider-initiated testing and counseling | |
| Number tested and received results | Please indicate the number of individuals receiving testing and counseling through provider-initiated HTC. |
| Number identified positive | Please indicate the number of individuals identified HIV positive through provider-initiated HTC. |
| VCT: Number of individuals tested through voluntary counseling and testing | |
| Number tested and received results | Please indicate the number of individuals receiving testing and counseling through voluntary HTC sites. |

| | |
|---|---|
| Number identified positive | Please indicate the number of individuals identified HIV positive through voluntary HTC sites. |
| CBTC: Number of individuals tested through community-based testing and counseling | |
| Number tested and received results | Please indicate the number of individuals receiving testing and counseling in community settings. |
| Number identified positive | Please indicate the number of individuals identified HIV positive through HTC in community settings. |
| **Post-exposure Prophylaxis (PEP)** | |
| P6.1.D: Number of persons provided with post-exposure prophylaxis (PEP) | The same as NGI P6.1.D, *Number of persons provided with post-exposure prophylaxis (PEP)*. |
| **Blood Safety (BS)** | |
| Number of Blood units collected | Related to NGI P2.1.N, *Percentage of donated blood units screened for HIV in a quality assured manner*. This is subset of the numerator, number of blood units collected. |
| **Orphans and Vulnerable Children (OVC)** | |
| Number of OVC reached | Related to indicator C5.1.D, *Number of eligible clients who received food and/or other nutrition services*; however, two adjustments are required: (1) please only report those individuals <18 years of age and (2) please include OVC reached with any type of support, not just food and nutrition. |
| Estimate the number of OVC beneficiaries reached receiving services in each of the following categories | Please indicate the number of OVC that were reached with support services in each of four service categories. It is understood that some individuals are reached with more than one service, and conversely, not all individuals receive all types of services. Therefore, the sum of beneficiaries reached across all service categories may be higher than the total number of OVC reported reached (previous indicator). The sum across all service categories should not be lower than the total number OVC reported reached. |
| Medical Care (not facility-based) | |
| Educational Support | |
| Social, Psychological and Spiritual Care | |
| Nutrition and food security | |
| **Sexual and Other Risk Prevention- General Population (SORP-GP)** | |

| | |
|---|---|
| P8.1.D: Number of general population reached | The same as NGI P8.1.D, *Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required*. |
| Estimate the number of beneficiaries reached through SORP-GP receiving services in each of the following categories | Please indicate the number reached with SORP activities, separated by those reached with mass media and those reached with individual and/or small group-level interventions. It is understood that some individuals are reached with both, and conversely, not all individuals receive both types of services. Therefore, the sum of beneficiaries reached across all service categories may be higher than the total number of beneficiaries reported reached through SORP (previous indicator). The sum across all service categories should not be lower than the total number reported reached. |
| Mass Media | |
| Individual and Small Group Prevention Interventions | |
| **Sexual and Other Risk Prevention- Most-at-Risk Populations (MARPs)** | |
| Number of MARP reached with individual and/or small group level interventions | The same as NGI P8.3.D, *Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required*. |
| **Voluntary Medical Male Circumcision (VMMC)** | |
| P5.1.D: Number of Males Circumcised | The same as NGI P5.1.D, *Number of males circumcised as part of the minimum package of MC for HIV prevention services* |
| **Health System Strengthening (HSS)** | |
| H2.1.D: Number of new health care workers who graduated from a pre-service training institution | The same as NGI H2.1.D. |

## ENTERING DATA

For each data entry row, please first select the region and province that correspond to each reported indicator. There should be a separate row for each province in which your organization provides site-level services and support. Use the quick links on the left side of the page for easy navigation between program areas. Entry fields have been separated by program area first, then indicator category. The program areas provided reflect PEPFAR service provision and support in COUNTRYNAME and do not correspond directly to the PEPFAR budget codes. Brief descriptions for each program area are provided below. If you need further explanation, please request TA (section 4.0).

- *Facility-based care, treatment, and support (FBCTS)* - Clinical care, support, and antiretroviral treatment (ART) provided in a health facility.
- *Community-based care, treatment, and support (CBCTS)* - Care, support, and ART provided in a community setting, outside of a traditional health facility. This includes any clinical care provided outside health facilities.
- *Prevention of mother-to-child transmission (PMTCT)* - Services for pregnant women and exposed infants which provide HIV testing and results; access to care ART and prophylaxis; and information on ways to protect themselves if negative.
- *HIV testing and counseling (HTC)* - Services providing HIV testing and results to individuals as well as counseling on how to remain negative for those who test negative and information on seeking care, treatment, and prevention services for those who test positive. HTC is further disaggregated by testing modality: provider-initiated (PITC), voluntary (VCT) and community-based (CBTC).
- *Post-exposure prophylaxis (PEP)* - Services providing prophylaxis for both occupational and non-occupational exposure to HIV.
- *Blood Safety (BS)* - Services and support for the collection and testing of blood units.
- *Laboratory (LAB)* - Provision of diagnostic services related to HIV clinical interventions (e.g., CD4 counts and tuberculosis testing), and system development support to renovate, train, and otherwise expand laboratory capacity and quality.
- *Orphans and vulnerable children (OVC)* - Services that target OVC needs in the areas of medical care (not facility-based), educational support, spiritual care, psychological care, social care and food and nutrition.
- *Sexual and other risk prevention-general population (SORP-GP)* - Biomedical prevention, behavioral prevention, and structural prevention interventions targeted to the general population versus specific sub-populations or groups.
- *Sexual and other risk prevention-most-at-risk populations (SORP-MARPs)* - Prevention activities and interventions specifically targeting most-at-risk or key populations
- *Voluntary medical male circumcision (VMMC)* - The provision of circumcision and support to males electing surgery.
- *Infection control (IC)* - Investments in renovating facilities and training health care workers to reduce the spread of infectious disease. This includes renovations and training for TB-HIV mitigation.

## 2.3 EXPENDITURES- SITE-LEVEL

You should complete this worksheet if your organization receives any PEPFAR funding to provide services or support at the facility/site/implementation-level. System-level expenditures that are not tied directly to patients/beneficiaries, facilities or communities should be reported on the program management, strategic information, or health system strengthening worksheets. Generally, if site-level indicators or program information is reported, site-level expenditures are expected as well. Expenditures should be linked to a specific province and classified by program area and cost category. Definitions for common cost categories can be found in **Table 2**. Within certain program areas some additional information is requested; explanations for these categories are provided below.

- *CBCTS*- Expenditures in this category should be classified first by cost category and second by service category. The relevant service categories are: medical care (not facility-based); economic strengthening; social, psychological and spiritual care; and nutrition and food security. The sum of expenditures in cells X22-AL22 should equal the sum of expenditures in cells AN22-AS22.
- *PMTCT*- Expenditures in this category should be classified first by cost category. You are also requested to estimate the percentage of staff time and program effort that is used to support services in four service categories: HIV testing for pregnant women, HIV testing for exposed infants, prevention and care for pregnant women and prevention and care for exposed infants. This should be your best estimate for how *shared* expenditures, such as personnel, building rental and utilities and travel/transport, should be allocated to core PMTCT activities. Finally, you are requested to provide some additional information on expenditures to assist

with allocating between core PMTCT services. This includes indicating the amount of total reported expenditures for HIV test kits that are used for testing pregnant women versus infants, as well as, indicating the amount of the total reported expenditures for ARVs that are provided to pregnant women versus infants.

- *HTC*- Expenditures in this category should be classified first by cost category and then by intervention model. The relevant intervention models are provider initiated testing and counseling (PITC), voluntary counseling and testing (VCT), and community-based testing and counseling (CBTC). The sum of expenditures in cells CJ22-CX22 should equal the sum of expenditures in cells CZ22-DB22.
- *Laboratory*- Expenditures in this category should be classified first by cost category. You are also requested to estimate the percentage of staff time and program effort that is used to support services in four categories: ART lab services, TB diagnostics, early infant diagnosis (EID), and quality assurance/quality improvement (QA/QI). This should be your best estimate for how *shared* expenditures, such as personnel, building rental and utilities and travel/transport, should be allocated to core lab services. Finally, you are requested to provide some additional information on expenditures to assist with allocating between core lab activities. This includes indicating the amount of total reported expenditures for non-ARV drugs and reagents and supplies that are used to support ART lab services, TB diagnostics, EID and QA/QI at the site-level.
- *OVC*- Expenditures in this category should be classified first by cost category and second by service category. The relevant service categories are as follows: medical care (not facility-based); educational support; social, psychological and spiritual care; and nutrition and food security. The sum of expenditures in cells GC22-GQ22 should equal the sum of expenditures in cells GS22-GX22
- *SORP-GP*- Expenditures in this category should be classified first by cost category and second by service category. The relevant service categories are mass media and individual and/or small group-level interventions. The sum of expenditures in cells GZ22-HN22 should equal the sum of expenditures in cells HP22-HT22

**Table 2. EA Cost Categories and Descriptions**

| Cost Category | Description |
|---|---|
| Investment Expenditures | Site-level program expenditures, both human and capital, that have a useful life of more than one year |
| Training (in-service) | Unlike most other cost categories, this is an activity. Expenditures in this category should include expenditures related to training such as workshop, per diem, travel, trainers and facilitators. In-service training supports the further capacity development of existing health workers and program staff *at the site-level*. In contrast, training that supports the creation of new health workers or supports the capacity development for government employees at the national-level should be classified should be entered on the Expenditures-HSS worksheet. Training is also unique from other categories in that the expenditure should be linked to province(s) to which the participants work, *not* the location where the training occurred. A fuller description of how to classify training expenditures is provided in section 3.4 |
| Construction and Renovation | Site-level expenditures for construction and renovation of existing health facilities or program offices. Construction and renovation that benefits multiple program areas will need to be allocated across program area columns. Construction and renovation of facilities that benefits the system as a whole (e.g., MOH offices) should be recorded on the Expenditures-HSS worksheet |
| Vehicles | Expenditures for the purchase of vehicles only. Fuel and maintenance expenditures should be recorded as recurrent expenditures under travel/transport |
| Equipment and Furniture | Site-level expenditures for the purchase of clinical and office equipment and |

| | |
|---|---|
| | furniture, including computers. Office supplies that are purchased and used up within a year should be recorded as recurrent expenditures |
| Other investment expenditures | Site-level investment expenditures otherwise not categorized. Explanations are required for this category to complete the submission |
| Recurrent Expenditures | Site-level program expenditures that are consumed within the year as part of normal program operations |
| Personnel | All expenditures related to personnel. This includes salary, fringe benefits, top-up salary and reimbursement for overtime |
| Antiretroviral Drugs (ARVs) | Expenditures for the purchase of ARVs. Only report in this category if your organization procured ARVs with PEPFAR funds over the EA timeframe |
| Non-ARV Drugs and Reagents | Expenditures for the purchase of any drugs not classified as ARVs and the purchase of reagents for laboratory diagnostics |
| HIV Test Kits | Expenditures for the purchase of HIV test kits |
| Condoms | Expenditures for the purchase of condoms |
| Other Supplies | Expenditures related to the purchase of any commodities or supplies that are otherwise not classified |
| Food supplements | Expenditures for the purchase of food supplements |
| Travel and Transport | This category includes all travel related expenditures such as airfare, bus fare, per diem, and vehicle fuel and maintenance. The *purchase* of mobile equipment, such as vehicles, should be categorized as investment expenditures |
| Other recurrent expenditures | Site-level recurrent expenditures otherwise not categorized. Explanations are required for this category to complete the submission |
| Program Management, Monitoring and Evaluation, Surveillance and Health System Strengthening Cost Categories | |
| Personnel | All expenditures related to personnel that support the program but do not work in sites. This includes salary, fringe benefits, top-up salary and reimbursement for overtime |
| Consultants (External) | All expenditures related to contracted services and consultant services (external to your organization) |
| Transport/travel | This category includes all travel related expenditures for above site-level personnel, such as airfare, bus fare, per diem, and vehicle fuel and maintenance |
| Other general and administrative | This category includes all above site-level expenditures not otherwise categorized as personnel, consultants or transport/travel |

## 2.4 EXPENDITURES- PM

You should complete this worksheet to record your organization's expenditures attributed to program management (PM) that occur above the facility/site/implementation-level. The program management expenditures are first classified into three categories: (1) *provincial*, (2) *national-level*, and (3) *above national-level*. *Expenditures should be recorded at the level where the resources are consumed*—within the province (provincial), within the country but above the province (national), or outside of the country (above national)—*not* the location where expenditures originate.

Expenditure data must also be recorded by cost category. There are four cost categories for above site-level expenditures: (1) *personnel*, (2) *consultants (external)*, (3) *transport/travel*, and (4) *other general/administrative*. Brief definitions for each can be found in **Table 2**. If you have specific questions about what should be included in this worksheet, please request technical assistance from the EA team.

Finally, for each location and associated expenditure recorded, you are asked to indicate what percentage of the expenditure is linked to each PEPFAR-defined program area. *The recommended allocation method for program management expenditures can be found in section 3.3.* If the recommended method is not used, you will be asked upon submission to provide an explanation of the allocation method chosen and explain the motivation for using the alternate method.

When entering data on each row, you must first select the province in which the program management expenditures occurred, or select "national" or "above-national" and the "not province specific" option. Next, you will enter the expenditure data corresponding to the selected location in the columns that best describe the expenditure by cost category. Finally, you will allocate the expenditures to each PEPFAR program area. The allocation percentages must total 100 by row.

## 2.5 EXPENDITURES SI AND SURVEILLANCE

You should only complete this form if your organization provides support for strategic information (SI) or surveillance activities. These expenditures are first classified into three categories: (1) *provincial*, (2) *national-level*, and (3) *above national-level*. *Expenditures should be recorded at the level where the resources are consumed*—within the province (provincial), within the country but above the province (national), or outside of the country (above national)—*not* the location where expenditures originate.

Expenditure data must also be recorded by cost category. There are four cost categories for above site-level expenditures: (1) *personnel*, (2) *consultants (external)*, (3) *transport/travel*, and (4) *other general/administrative*. Brief definitions for each can be found in **Table 2**. If you have specific questions about what should be included in this worksheet, please request technical assistance from the EA team.

Finally, for each location and associated expenditure recorded, you are asked to indicate what percentage of the expenditure is linked to each PEPFAR-defined program area. *The recommended allocation method for SI expenditures can be found in section 3.3.* If the recommended method is not used, you will be asked upon submission to provide an explanation of the allocation method chosen and explain the motivation for using the alternate method.

When entering data on each row, you must first select the province in which the expenditures occurred, or select "national" or "above-national" and the "not province specific" option. Next, you will enter the expenditure data corresponding to the selected location in the columns that best describe the expenditure by cost category. Finally, you will allocate the expenditures to each PEPFAR program area. The allocation percentages must total 100 by row.

## 2.6 EXPENDITURES HSS

You should only complete this form if your organization provides support for Health System Strengthening (HSS). The HSS expenditures are first classified into three categories: (1) *provincial*, (2) *national-level*, and (3) *above national-level*. *Expenditures should be recorded at the level where the resources are consumed*—within the province (provincial), within the country but above the province (national), or outside of the country (above national)—*not* the location where expenditures originate.

Expenditure data must also be recorded by cost category. There are four cost categories for above site-level expenditures: (1) *personnel*, (2) *consultants (external)*, (3) *transport/travel*, and (4) *other general/administrative*. Brief definitions for each can be found in **Table 2**. If you have specific questions about what should be included in this worksheet, please request technical assistance from the EA team.

In addition to cost category, you are asked to report total HSS expenditures by functional area. **Table 3** provides a list of functional areas and definitions. If you need further explanation, please request assistance. The sum of cells H22-L22 should equal the sum of cells N22-Y22.

Finally, for each location and associated expenditure recorded, you are asked to indicate what percentage is linked to each PEPFAR-defined program area. As HSS activities typically benefit the system as a whole, rather than specific program areas, you are asked to use a reasonable method for these allocations. Though not exact, this will help the PEPFAR team understand how investments in HSS may benefit particular programs and provinces.

When entering data on each row, you must first select the province in which the expenditures occurred, or select "national" or "above-national" and the "not province specific" option. Next, you will enter the expenditure data corresponding to the selected location in the columns that best describe the expenditure by cost category. Finally, you will allocate the expenditures to each PEPFAR program area. The allocation percentages must total 100 by row.

**Table 3. Health System Strengthening (HSS) Functional Areas and Descriptions**

| HSS Functional Area | Description |
|---|---|
| **Human Resources (HR)** | |
| Pre-service Training | The basic education required to provide a set of basic skills competencies needed by all health care workers within a specific cadre (e.g. physicians, midwives, nurses, CHWs) that will be used throughout their careers |
| Training of Trainers | Theoretical or practical training for teachers and trainers who in turn will train other staff |
| Curriculum Development | Technical Assistance (consultant time, resources etc) provided to develop curriculum (not teaching or training cost on the curriculum developed) |
| HR Management and Retention | Direct funding to and capacity building to create human resource management systems. Examples may include: human resource policies, guidelines, and standards for hiring, career progression, promotion, and performance measures, human resource technical accreditation, development and implementation of HR decision-making instruments including surveys for tracking and assessing workload and flow at healthcare delivery sites. |
| **Governance** | |
| Technical Area Specific Guidelines, Tools and Policy | Development and implementation of policy, advocacy, guidelines and tools that are related to a specific technical area such as Treatment and Care, PMTC, HTC, OVC etc. Example of such an activity is advocacy efforts or development of circular/guidelines on use of Rapid test for HCT |

| | |
|---|---|
| General Policy and Other Governance | Developing, implementing and enforcing policies that affect the health system and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability. Examples of general policy work are advocacy around closing of detention centers, Inter-ministerial circulars, modifying the Law on Handling Administrative Violations - it is the main regulatory document that serves as a basis for formulating regulatory documents on handling administrative violations and adopting administrative sanctions in Vietnam. These include sanctions for acts of violations of HIV/AIDS prevention and control regulations and other social HIV/AIDS-related issues, such as drug addiction and sex work |
| **Finance** | |
| Finance | Raises, accumulates and allocates adequate funding for health sector; consists of the payer, providers and consumers of health services. |
| **Systems Development** | |
| Supply Chain Systems | Development of a supply chain system entails two types of costs: Fixed costs and Operational costs. Fixed costs include infrastructure such as warehouse, trucks, computer systems that might need to be added or improved to develop the system. Operational costs include adding human resources, training of a new cadre employees with new skills, advocacy work and technical assistance for the system development (i.e. designing a new inventory system or holding a stakeholder meeting to get buy in for the system), as well as ensuring the expendable supplies to run the system are in place such as fuel, electricity, internet, etc. |
| Health Information Systems (HIS) | Ensure the production, analysis, dissemination and use of reliable, timely information on health determinants, health systems performance and health systems |
| Laboratory Strengthening | Direct funding to and capacity building assistance, other than training, for Quality assurance (QA)/Quality Improvement (QI), which is the practice of assessing and evaluating performance relative to standards to ensure the quality of services and outcomes and/or the practice of using techniques and methods to introduce and implement changes or adjustments for better performance and outcomes. This includes resources spent on the development of indicators, developing guidelines, supervision and monitoring visits and coaching, and other related expenditure. This category also includes direct funding to or capacity building assistance for all other laboratory strengthening activities that occur above the site-level, including all aspects of quality management systems, accreditation activities, implementation of laboratory information systems and technical assistance to assure or improve quality of laboratory services. |
| **Institutional and Organizational Development** | |
| Civil Society and Non-Governmental Organizations (NGOs) | Direct funding to and capacity building assistance to sustain local civil society organizations and other local non-governmental-- organizations, institutions, faith-based organizations, and community-based organizations. Examples include strengthening internal structures, administrative systems and processes, program/project management, leadership, governance, resource mobilization and overall staff capacity; mentoring, technical assistance and trainings to develop systems and standard operating procedures, documents or tools (e.g. leadership development and team building, financial management, internal business operations and procedures). |
| Government Institutions | Direct funding to and capacity building assistance to governmental organizations to strengthen the capacity of host country government institutions to plan, finance, manage, implement and monitor public health programs. Examples include strengthening internal institutional structures, administrative systems and processes, program/project management, leadership, governance, resource mobilization and overall staff capacity; |

| | |
|---|---|
| | mentoring, technical assistance and trainings to develop systems and standard operating procedures, documents or tools (e.g. leadership development and team building, financial management, internal business operations and procedures). |

# 3.0 ALLOCATION METHODS FOR SHARED AND ABOVE SITE-LEVEL EXPENDITURES

Many program expenditures are shared by multiple program areas or provinces. Below are some recommended methods for allocating shared expenditures. If your organization uses an alternate method (not described in this manual), please include a notation describing the methods used in the text fields provided in the data collection instruments.

## 3.1 ALLOCATING SHARED EXPENDITURES ACROSS PROGRAM AREAS

If your organization provides services to beneficiaries in multiple PEPFAR-defined program areas you will need to allocate these expenditures appropriately. Choosing the appropriate method depends on the type of expenditure.

### INVESTMENT EXPENDITURES

If your organization used PEPFAR resources to train staff, invest in construction or renovation, or procure clinical or office equipment that served multiple program areas over the period, you will need to estimate the proportion of the investment that should be recorded in each program area column. This can be accomplished by multiplying the total amount spent for the investment by an estimate of use by each program area. For example, if your organization purchased computer equipment for 1,000 USD that is used to support both a community outreach program for MARPs and HTC sites, you should estimate how frequently the computer was used for each activity. In this example, a reasonable proxy for allocating the expenditure may be the amount of time program staff devote to community outreach versus HTC activities. If your program staff estimate that (on average over the period) MARP activities accounted for 80% of time and HCT 20% of time, you would (1) record the full $1,000 as a recurrent expenditure in the equipment and furniture column of the Expenditures- Site-level worksheet and (2) allocate the expenditures by recording 80 in the SORP-IDU column and 20 in the HTC column.

### RECURRENT EXPENDITURES

If your organization used PEPFAR resources to support recurrent expenditures that served multiple program areas over the period, you will need to estimate the proportion of the recurrent expenditures that should be recorded in each program area column. This can be accomplished by multiplying the total expense by an estimate of use by each program area. For example, if your organization rents a building that is used to support FBCTS and PMTCT, you should estimate how much of the building expense was used for each activity. One method is to determine how much of the total building space is devoted to each activity. This method works well if each activity has a dedicated space. For example, a clinic may have clinic rooms devoted to ART and clinic rooms devoted to PMTCT. In this case you may estimate the percentage of building space that is occupied by each activity and multiply this by the total expense to allocate to multiple program areas. It is often likely, however, that in health facilities all building space is shared by activities, e.g. ART and PMTCT patients are seen in the same clinic room. In this example, allocating rent by dedicated building space will not work and another allocation method needs to be selected. Another option is to allocate the shared building expense by patient volume. If a health facility sees 55 ART patients per day and 45 PMTCT patients per day you could allocate 55% of the total building rent to ART and 45% to PMTCT. There may also be some other method that is most suitable for your organization based on the

program areas covered and service delivery model. If you allocate shared recurrent expenditures by some other method than described here, please use the text fields in the data collection instrument to notate.

## 3.2 ALLOCATING SHARED EXPENDITURES ACROSS PROVINCES

For this activity, your organization is asked to enter expenditure data by province. The key is to record expenditures based on the location the resources were consumed. If your organization provides services to beneficiaries in multiple provinces you will need to allocate these expenditures appropriately. Choosing the appropriate method depends on the type of expenditure.

### INVESTMENT EXPENDITURES

Most investment expenditures should be easily tied to a specific location. Notable exceptions may include the purchase of vehicles or mobile equipment. For investment expenditures that support multiple provinces, you will need to estimate the proportion of the investment that should be recorded for each province on unique data entry rows. This can be accomplished by multiplying the total amount spent for the investment by an estimate of use by each program area. For example, if your organization purchased a vehicle for 10,000 USD that is used to support activities in three provinces, you should estimate how frequently the vehicle was used in each province. Program staff or drivers should be able to provide this information. If staff estimate the vehicle is used roughly equally across the three provinces, you would (1) divide the $10,000 by three, (2) select the appropriate provinces on three unique data entry rows, and (3) record $3,333 (10,000/3) in the vehicles column on each row.

### RECURRENT EXPENDITURES

If your organization used PEPFAR resources to support recurrent expenditures that served multiple provinces over the period, you will need to estimate the proportion of the recurrent expenditures that should be recorded on each unique data entry row. For example, if your organization procured commodities, such as drugs for opportunistic infections (OI), over the period that were consumed in several provinces you will need to allocate the expenditure to each province receiving the drugs and enter the data on a separate row corresponding to each province where the resources were consumed. It is expected drugs and other commodities are tracked to the facilities they support and there would not be a need to be much estimation for allocating between provinces. Site-level personnel, however, may be shared by sites stretching across provincial boundaries and the costs associated with these personnel will need to be allocated according to an estimate of time spent in each province.

## 3.3 ALLOCATING PROGRAM MANAGEMENT AND OTHER CROSS-CUTTING EXPENDITURES

### PROGRAM MANAGEMENT

Expenditures for program management (PM) and monitoring and evaluation (M&E) that occur above the site-level will need to be (1) linked directly to a province or tagged as not province specific (national or above national), (2) classified by cost category, and (3) distributed to the program areas they support. How your organization distributes your PM and M&E expenditures by program area should correspond to the expenditures recorded in the Expenditures-Site-level worksheet. *Note: all expenditures tagged as not province specific will be redistributed to specific provinces and program areas based on the information you provide.*

For example, assume an implementing partner (IP) provides FBCTS and PMTCT services in two provinces (A and B), maintains a headquarters office in the country's capital city, and has grant management staff supporting the organization from the home country office. The IP supplies the following data:

| *Location where resources are consumed* | *Expenditures- Site-level* | | *Expenditures- PM* |
|---|---|---|---|
| | FBCTS | PMTCT | |
| Province A | $500,000 | $200,000 | $100,000 |
| Province B | $200,000 | $100,000 | $50,000 |
| National | -- | -- | $400,000 |
| Above National | -- | -- | $100,000 |

The IP needs to allocate expenditures for PM in the last column to the program areas supported. For PM expenditures in the provinces, the allocation should match the distribution of site-level expenditures by program area *unless there is valid reason why this method would not be accurate for your particular organization.* To calculate the allocations for province A, add the total site-level expenditures ($500,000+$200,000=$700,000) and divide the expenditures for each program area by the total:

FBCTS= $500,000/$700,000= 72%

PMTCT= $200,000/$700,000= 28%

The $100,000 for program management in province A would therefore be recorded on the Expenditures-PM worksheet on a unique row with the province name selected; 72 would be entered in the FBCTS column and 28 would be entered in the PMTCT column. The same method should be used to determine the allocation for the $50,000 PM expenditure in province B:

FBCTS= $200,000/$300,000= 67%

PMTCT= $100,000/$300,000= 33%

Not province specific program management (national and above national) may be less easily tied to specific program areas; however, by using a similar method PEPFAR IPs can approximate how these expenditures support actual delivery of services and support, which helps to fill a crucial data gap. To calculate the allocations by program area, first add the total site-level expenditure for the IP:

$500,000+$200,000+$200,000+$100,000= $1,000,000

Next, add the total expenditures for each program area across provinces:

FBCTS= $500,000+$200,000= $700,000

PMTCT=$200,000+$100,000= $300,000

Next, calculate the distribution of total site-level resources used to support each program area:

FBCTS= $700,000/$1,000,000= 70%

PMTCT=$300,000/$1,000,000= 30%

Finally, record the national and above national expenditures on two unique data entry rows in the Expenditures-PM worksheet and enter 70 in the FBCTS column and 30 in the PMTCT column. The same allocation percentages calculated above will apply to both national and above national expenditures.

These allocation methods are intended to approximate how above site-level program expenditures support program achievements and will not be exact for every organization. You may use alternate methods if your organization believes there is a more accurate way of attributing these expenditures to provinces and program areas; however, you will be asked to provide a justification and description of the method used. The default data check will use the methods described above and the system will not allow instruments to be successfully submitted if the default method has not been used and there is no justification provided in the notes.

### MONITORING AND EVALUATION

Allocation of monitoring and evaluation (M&E) expenditures should follow the same methods as described above unless there is reason to believe the distribution would not accurately reflect your specific program. For example, if the IP data provided above also included $1,000,000 of M&E expenditure that was used to support a clinical trial to determine the optimal ARV regimen for pregnant mothers, allocating 70% to FBCTS would not be appropriate. In this case, the full 100% of M&E expenditure should be allocated to PMTCT. Please indicate in the notes the justification for using an alternate method.

### HEALTH SYSTEM STRENGTHENING

You are asked to record total health system strengthening expenditures in two ways: (1) by cost category and (2) by functional category. Additionally, you are asked to allocate HSS expenditures to program areas. Since HSS projects typically benefit multiple program areas or the health system as a whole, this information should be your best estimate based on your knowledge of the projects. There is not a recommended allocation method, although the methods described above for PM and M&E are suitable if they accurately describe how HSS dollars benefit program areas within a reasonable margin of error.

### TECHNICAL ASSISTANCE

Your organization may have staff that provide program management support as well as technical assistance at the system-level for activities such as M&E, surveillance or in an area of HSS. For example, the Chief of Party for a PEPFAR-supported organization spends some of her time working with MOH staff to develop appropriate systems at the national level to better recruit and train skilled health workers. The remainder of her time is spent managing the normal operations of the program. The total expenditure recorded for her salary over the period should then be recorded in at least two places: (1) Expenditures-PM-Personnel and (2) Expenditures-HSS-Personnel-HR Management and Retention. Determining the right allocation between the relevant categories will require an estimate for the amount of time the Chief of Party is engaged in each activity over the period.

## 3.4 TRAINING

Training is a unique category and expenditures for training can be recorded in more than one location in the data collection instrument. This guide will provide step-by-step instructions for assessing your organization's training expenditures how best to report them for EA.

- *Step 1*- Determine if the training is *in-service* or *pre-service*. If the training lead to the graduation of new health worker (see specific definition in **Table 3**) then it should be classified as pre-service and reported on the Expenditure-HSS worksheet [move to **Step 3B**]. If the training did not lead to the graduation of a new health worker, the training should be categorized as *in-service* [move to **Step 2**]

- *Step 2*- Determine if the in-service training should be classified as *site-level* or *HSS* expenditure. Who were the participants? If the participants (trainees) are health workers or otherwise engaged in the direct provision of HIV-related clinical or support services to beneficiaries, the training should be classified as *site-level* [move to *Step 3A*]. If the participants (trainees) are not involved in the direct provision of HIV-related services but support the system at a higher level, the training should be classified as *HSS* [move to **Step 3B**]
- *Step 3A*- Determine how to allocate training expenditures between provinces and program areas. Training is the one exception to the EA rule, *record expenditures in the location where the resources are consumed*. Since so many trainings happen at the regional or national-level, it is important to understand how these trainings are benefitting specific provinces and programs. There are two potential strategies for allocating expenditures between provinces:
    - → *Method 1*- If your organization keeps a record of the participants and which province they work in, you can allocate expenditures for trainings proportional to the origin of the participants. For example, your organization spent 10,000 USD on a training for 30 clinicians focusing on capacity building to improve ART adherence. The training was held in Hanoi but participants came from 5 surrounding provinces. You can review your records to determine the distribution of attendees by province:

| *Province* | *Number of Participants Originating from Province* | *Percent of Total Participants from Each Province* |
|---|---|---|
| 1 | 10 | 33% |
| 2 | 7 | 23% |
| 3 | 5 | 17% |
| 4 | 5 | 17% |
| 5 | 3 | 10% |
| All | 30 | 100% |

The percentage originating from each province can be calculated by dividing the number of participants from a given province by the total number of participants. You can then apply this distribution to the total expenditure for the training. For example, 3,300 USD would go to Province 1 (33% of 10,000), 2,300 USD would go to Province 2 (23% of 10,000), etc. When entering data in the instrument, a separate row should be started for each province represented and the expenditures recorded under Expenditures- Site-level- Training (in-service).

- → *Method 2*- If your organization does not track the origin province for each participant of a training, you will need to use an alternate method for allocating the expenditures between provinces. Another, less specific method is to divide the total training expenditure equally by all provinces represented. Therefore, in the above example all 5 provinces would have 2,000 USD recorded under Expenditures- Site-level- Training (in-service).

After allocating the training expenditure to the appropriate provinces on the Expenditures-Site-level worksheet, you must also allocate expenditures between program areas according to the content of the training. In the above example, the training was directed for clinicians providing ART. As a result, all or most

should be allocated to FBCTS (some may be allocated to PMTCT or CBCTS if relevant). If trainings are focused on more than one program area, you will need to use some reasonable method to allocate expenditures between program areas. If you need assistance with this allocation, please contact the study team.

- *Step 3B*-There is not a cost category specifically for training on the HSS worksheet, so please categorize the costs according to the provided categories. For example, if an external trainer was contracted and the venue was paid by the organization, the expenditure for the trainer should be categorized as Consultants (external) and the expenditure for the venue should be categorized as Other general/administrative.

  In addition to recording expenditures by cost category, you must categorize the expenditure for training by HSS function area. Please choose the area that best describes the nature of the training (descriptions of functional areas in **Table 3**).

  Finally, you will need to indicate how the HSS expenditure for training should be allocated to PEPFAR program areas. This percentage is a best estimate.

# 4.0 DATA SUBMISSION AND TECHNICAL SUPPORT

## 4.1 ACCESSING PROMIS AND SUBMITTING DATA

Completed data collection instruments should be submitted via the PROMIS website no later than **16 November 2012**. The link to the PROMIS site is provided below. A presentation with step-by-step instructions for downloading data collection workbooks and uploading completed submission can be found on the PROMIS website under the "Help" link.

*https://pepfarpromis.net/Vietnam.PROMIS.web/*

In order to access PROMIS, your organization must specify users and provide contact information and valid email addresses. It is recommended that at least two (2) individuals have access to the system. Instructions will be provided by the PC/S for submitting users for system access.

## 4.2 TECHNICAL ASSISTANCE

If you should need technical assistance in completing the data collection workbook, allocating expenditures, accessing the PROMIS system, uploading completed submissions or with other issues pertaining to EA, please submit a helpdesk ticket on the PROMIS website. Please provide enough detail in the request that it will be routed to the appropriate technical authority. Your AM/A/COTR should be copied on any TA requests.

Thank you in advance for your support and diligence in providing the requested data. The results of this analysis will help to improve planning for USG-supported HIV programs in COUNTRYNAME.

## Appendix I. PROMIS Privacy Statement

- This site is only accessible to authorized PROMIS users with an assigned user identifier and associated password. All transmissions to and from the PROMIS application are protected and secured via SSL encryption.
- PROMIS tracks and associates the following information to each user:
    - User name – this information is used to ensure a user is uniquely identified within PROMIS.
    - User organization – this information is used to limit access to only those elements of PROMIS data relevant to your organization.
    - User email address – this information is maintained to support user notifications such as a notice for a required password change, a notice to review the site terms of use, etc.
    - User roles & privileges – this information is used to further limit access to only those PROMIS functional capabilities and elements of PROMIS data that are relevant to your role within your organization.
    - Each user log-on session to include log-in time and log-out time – this information is used to assess the appropriateness of your access to the PROMIS web site.
    - Each PROMIS data element entered, updated, or deleted by you in the course of your interactions with PROMIS – this information is used to track PROMIS data change history, to assess inappropriate PROMIS data changes, and to provide a means to identify data that may need to be corrected at a future date.
- The PROMIS hosting services provider also tracks information to support site performance to include:
    - The browser used when accessing PROMIS.
    - The time and date of each visit to the PROMIS log-in page.
    - The PROMIS web pages visited.
    - The address of the web site visited immediately prior to visiting the PROMIS web site.
    - Any malicious actions against the PROMIS web service.
- Your information will not be disclosed, given, sold, or transferred unless required for law enforcement or otherwise required by law.
- This site is maintained by the U.S. Government and is protected by various provisions of Title 18, U.S. Code. Violations of Title 18 are subject to criminal prosecution in Federal court.

**Use of Cookies**

- The PROMIS website maintains both session-based and persistent “cookies” on your browser. PROMIS session-based cookies store text information temporarily in your computer’s random access memory (RAM) while you are using PROMIS. When you close your web browser, these cookies are removed. PROMIS persistent cookies store information for a longer period and are used to identify returning PROMIS users.

**HIPAA Privacy Rule Notice**

- The PROMIS web site does not collect or maintain individually identifiable Protected Health Information (PHI). While PEPFAR Partners may have access to such information from their health service provider Sub-Partners in-Country, PROMIS provides for entry of only aggregated results by pre-defined health Indicator.